

**COVENTRY HEALTH CARE OF NEBRASKA, INC.**  
**City of Lincoln - Schedule of Benefits**

<b>2006</b>	<b>In Network Preferred Benefits</b>	<b>Out-of-Network</b>
<b>Physician Office Services : (Family Practice, General Practice, Internal Medicine, Pediatrics)</b> <ul style="list-style-type: none"> <li>• Physician office visits for routine physical, injury, or sickness</li> <li>• Pediatric and Well Child Care including immunizations</li> <li>• Diagnostic X-ray and laboratory (in Physicians Office)</li> <li>• Physician office visit for routine maternity services</li> </ul>	\$15 Copayment	Deductible and Coinsurance
<b>Specialty Physician Office Services:</b> <ul style="list-style-type: none"> <li>• Specialty Physician office visits for routine physical, injury, or sickness</li> <li>• Diagnostic X-ray and laboratory (in Physicians Office)</li> <li>• Specialty Physician office visit for routine maternity services</li> </ul>	\$15 Copayment	Deductible and Coinsurance
<b>Inpatient Hospital Services</b> <ul style="list-style-type: none"> <li>• Unlimited Hospital Days (Semi-Private Room and Board)</li> <li>• Private Room and Board when Medically Necessary</li> <li>• Professional Services</li> <li>• Maternity Care</li> <li>• Medications and Drugs</li> <li>• X-ray and Laboratory</li> <li>• Intensive/Coronary Care</li> <li>• Radiation Therapy</li> <li>• Administration of Blood</li> </ul>	Deductible and Coinsurance	*Deductible and Coinsurance
<b>Transplants</b> <i>(When performed at a Coventry Transplant Network Facility approved by CHC)</i>	Deductible and Coinsurance	No Out-of-Network Benefit
<b>Outpatient Hospital Services</b> <ul style="list-style-type: none"> <li>• X-ray and Laboratory</li> <li>• Ambulatory Surgery</li> <li>• Professional Services</li> <li>• Diagnostic Procedures</li> </ul>	Deductible and Coinsurance	*Deductible and Coinsurance
<b>Short Term Therapies</b> For maximum benefit coverage all services require prior authorization <ul style="list-style-type: none"> <li>• Speech, Occupational, Respiratory, and Physical (60 visits per calendar year for combined therapies)</li> <li>• Cardiac Rehabilitation (therapy is covered per calendar year up to 36 visits)</li> </ul>	\$15 Copayment	*Deductible and Coinsurance
<b>Other Therapies</b> No prior authorization is required for <ul style="list-style-type: none"> <li>• Manipulative (24 visits per calendar year)</li> </ul>	\$15 Copayment	*Deductible and Coinsurance
<b>Voluntary Family Planning</b> For maximum benefit coverage all services require prior authorization Elective Sterilization, Male or Female <ul style="list-style-type: none"> <li>• In office</li> <li>• Outpatient</li> </ul> Infertility Services (diagnostic services only)	\$15 Copayment  Deductible and Coinsurance  *Deductible and 50% Coinsurance	*Deductible and Coinsurance   *Deductible and 50% Coinsurance
<b>Nursing Facility</b> For maximum benefit coverage all services require prior authorization Limited to 60 days per calendar year	Deductible and Coinsurance	*Deductible and Coinsurance

<b>2006</b>	<b>In Network Preferred Benefits</b>	<b>Out-of-Network</b>
<b>Home Health Care</b> For maximum benefit coverage all services require prior authorization Limited to 60 days per calendar year	Deductible and Coinsurance	*Deductible and Coinsurance
<b>Hospice</b> For maximum benefit coverage all services require prior authorization 360 day lifetime maximum	Deductible and Coinsurance	*Deductible and Coinsurance
<b>Prosthetic Devices</b> For maximum benefit coverage all services require prior authorization. Limited to 2,500 per calendar year.	Deductible and Coinsurance	*Deductible and Coinsurance
<b>Durable Medical Equipment (DME)</b> For maximum benefit coverage all services require prior authorization. Limited to 2,500 per calendar year.	Deductible and Coinsurance	*Deductible and Coinsurance
<b>Urgent care center</b> • At an Urgent Care Facility	\$35 Copayment	Deductible and Coinsurance
<b>Emergency Health Services</b> • Hospital emergency room  • Ambulance Ground transportation Air transportation	\$100 Copayment   Deductible and Coinsurance	\$100 Copayment   Deductible and Coinsurance
<b>Deductible (Per Calendar Year)</b> • Individual • Family (Aggregate)	<b>\$300</b> <b>\$600</b>	<b>\$300</b> <b>\$600</b>
<b>Coinsurance (Per Calendar Year)</b>	10%	20%
<b>Out-of-Pocket Maximum: (does not include deductible)</b> • Individual • Family (Aggregate)	\$ 500 \$1,000	\$1,250 \$2,500
<b>Maximum Benefit:</b>	Unlimited	\$1,000,000

**Note:** Copays do not apply to the Out-of-Pocket Maximum. Flat dollar copays are not subject to the deductible. Failure to request prior authorization when and as required. May result in reduced benefits and in some instances, Benefits may be denied. Out-of-Pocket contributions may also be reduced or denied.

\* Services where prior authorization is the covered member's responsibility.

#### **Exclusions & Limitations**

Services not covered include: services that are not medically necessary; personal or convenience items; custodial care; cosmetic services and surgery; over-the-counter drugs and medications not requiring a prescription; experimental procedures and treatments; and food or food supplements. For maximum benefit coverage all services, except in the case of a Medical Emergency and Out-of-Area Urgent Care, should be rendered or authorized by Participating Providers.

Members are required to obtain prior authorization for planned hospital admissions and for elective surgeries. Contact Coventry Health Care of Nebraska, Inc. prior to a hospital admission or elective surgery. A penalty of 20% of the Out-of-Network Rate will apply if you do not prior authorize a planned hospitalization. Penalties do not apply towards the out-of-pocket-maximum.

**This Schedule is part of Your Summary Plan Description (SPD) but does not replace it. Many words are defined elsewhere in the SPD and other limitations or exclusions may be listed in other sections of your SPD. Reading this Schedule by itself could give you an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your SPD. A complete list of Covered Services, Exclusions, and Limitations can be found in Your SPD.**